STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005042	A. BUILDING: _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRE HAUTE REGIONAL HOSPITAL	3901 S SEVENTH ST TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for the investigation of one (1) State complaint. Complaint number: IN00155119 Unsubstantiated; lack of sufficient evidence. Date of survey: 12/17/14 Facility number: 005042 Surveyor: Jennifer Hembree RN Public Health Nurse Surveyor Terre Haute Regional Hospital is in compliance with 410 IAC 15-1.5-2 Infection Control and 410 IAC 15-1.5-6 Nursing Services. QA Review: JLee 01-21-15	S 000		